Welcome to our office! Please complete all questions completely and accurately!

ABOUT THE CHILD

Name _____

Address _____

City _____ State _____ Zip _____

Home phone _____ Birth date _____

Age _____ Gender _____ Weight _____

ABOUT THE PARENT

Name _____

Employer _____

Work address _____

Work phone _____

Type of work _____

Marital Status _____

Social Security # _____

E-mail address _____

Payment Method for First Visit ❑ Cash ❑ Check ❑ Credit card

VACCINATIONS

Have you chosen to vaccinate your child? ❑ Yes ❑ No

If yes, check all that your child has received.

❑ DPT ❑ MMR ❑ Chicken Pox ❑ Hepatitis ❑ Other

Describe any and all reactions to vaccine(s).

_____

REASON FOR THIS VISIT

Current Health Complaints/Reasons for consulting our office.

1. _____
2. _____
3. _____
4. _____

Is the purpose of this appointment related to

❑ Sports ❑ Auto ❑ Fall ❑ Home Injury
❑ Chronic Discomfort ❑ Other

Please explain _____

When did this condition begin? _____

Has this condition

❑ gotten worse ❑ stayed constant ❑ comes and goes

Does this condition interfere with

❑ Sleep ❑ Daily routine ❑ other activities

Please explain _____

Has this condition occurred before? ❑ Yes ❑ No

Please explain _____

Have you seen other doctors for this condition?

❑ Yes ❑ No

Doctor's Name(s) _____

Type of treatment _____

Results _____

AWARENESS OF CHIROPRACTIC PRINCIPLES

Were you aware that	Yes	No
• Doctors of Chiropractic work with the nervous system?	❑	❑
• The nervous system controls all bodily functions and systems?	❑	❑
• Chiropractic is the largest natural healing profession in the world?	❑	❑
• If Chiropractic care starts at birth, you can achieve a higher level of health throughout life?	❑	❑

EXPERIENCE WITH CHIROPRACTIC

Who can we thank for referring you to this office? _____

Have you personally been adjusted by a Chiropractor before? ❑ Yes ❑ No _____
Reason for those visits? _____

Doctor's name _____ Approximate date of last visit _____

Has your child been adjusted by a Chiropractor? ❑ Yes ❑ No Approximate date of last visit _____

Has any adult in your family seen a Chiropractor? ❑ Yes ❑ No

CHILD'S HEALTH HISTORY

Please check each of the diseases or conditions that the child has now or has had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.

- ❑ Allergies
- ❑ Asthma
- ❑ Attention problems
- ❑ Bed wetting
- ❑ Breathing problems
- ❑ Colic
- ❑ Constipation
- ❑ Digestive problems
- ❑ Ear problems
- ❑ Frequent colds
- ❑ Headaches
- ❑ Hyperactivity
- ❑ Irritability
- ❑ Skin problems
- ❑ Sleeping disorders
- ❑ Tubes in the ears
- ❑ Vision problems
- ❑ Other _____

CHILD'S CURRENT HEALTH STATUS

	No	Yes	If Yes, please explain
Has your child ever:			
…taken antibiotics?	❑	❑	_____
…been hospitalized?	❑	❑	_____
…had a severe fall?	❑	❑	_____
…been in a car accident?	❑	❑	_____
Is your child			
…accident prone?	❑	❑	_____
…currently taking any medication(s)?	❑	❑	_____
…having difficulty interacting with others?	❑	❑	_____

Have you or anyone else noticed that your child is nervous, twitches, shakes or exhibits rocking behavior?

_____

What changes (if any) in your child's health or behavior would you like accomplished?

_____

AUTHORIZATION TO CARE FOR A MINOR CHILD

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their bodies. Your Doctor will weigh your needs and desire for your child(ren) when recommending his/her treatment program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

❑ **Relief care** – Symptomatic relief of pain or discomfort

❑ **Corrective care** – Correcting and relieving the cause of the problem as well as the symptoms

❑ **Comprehensive care** – Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care

❑ I want the Doctor to select the type of care appropriate for my condition.

_____ _____

Parent or legal guardian's name (print) Patient's name (print)

_____ _____ _____

Parent/Guardian's signature Date Witness' signature